

R.N.

Journal for nurses

How R.N.'s Live

Alta Bates—
Community Hospital
and Nurse

When, Where, and
How to Invest



February 1954



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Fresh-Frozen and Freshly-Squeezed Orange Juice

Two years ago, findings of importance to dietitians everywhere were published, emphasizing the superiority of reconstituted MINUTE MAID Fresh-Frozen Orange Juice over home-squeezed juice of the same type oranges, in three respects:

(a) *Average levels of ascorbic acid significantly higher:* Obviously, this advantage of MINUTE MAID, observed in samples tested, is susceptible to variation, from season to season, as crops differ. It should be emphasized, however, that, penny for penny and year after year, the lower-priced MINUTE MAID offers more ascorbic acid than home-squeezed orange juice.

(b) *Peel oil content significantly lower:* Samples of orange juice, home-squeezed by typical housewives, showed that contents of peel oil, a cause of allergic response and poor tolerance, especially in infants, were up to 700% higher than in MINUTE MAID!

(c) *Bacterial counts dramatically lower:* Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed juice, but were uniformly low in MINUTE MAID.

Since publication of the above, more and more physicians are recommending MINUTE MAID in place of home-squeezed orange juice. And now comes more evidence in favor of MINUTE MAID . . .

New Assays Reaffirm Dietary Advantages of Minute Maid Fresh-Frozen Orange Juice on a Cost Basis

A second report comparing the individual mineral and vitamin values of MINUTE MAID Fresh-Frozen Orange Juice and home-squeezed juice of the same type oranges has recently been published. In this latest study, each sample was analyzed separately:

Although the results are again susceptible to variation according to crop and year, Fresh-Frozen MINUTE MAID was equal to the home-squeezed juice in the samples tested for the largest number of components listed; and in the mean values for iodine, manganese, potassium, Vitamin A and Vitamin B₁₂, MINUTE MAID showed appreciably higher values.

TABLE: Mean Values in Samples Tested

COMPONENT	UNITS	MINUTE MAID FRESH-FROZEN ORANGE JUICE	HOME- SQUEEZED ORANGE JUICE
Betaine	mg./100 ml.	49	46
Biotin	mcg./100 ml.	0.26	0.26
Choline	mg./100 ml.	12	12
Cobalt	mcg./100 ml.	74	67
Folic acid	mcg./100 ml.	2.2	2.2
Iodine	mcg./100 ml.	0.24	0.21
Manganese	mcg./100 ml.	33	18
Nitrogen			
Total	mg./100 ml.	104	79
Amino	mg./100 ml.	22	22
Volatile	mg./100 ml.	8	7
Non-volatile	mg./100 ml.	96	72
Pantothenic acid	mcg./100 ml.	146	145
Para-amino-benzoic acid	mcg./100 ml.	4	4
Phosphorus	mg./100 ml.	19	18
Potassium	mg./100 ml.	380	290
Riboflavin	mcg./100 ml.	18	17
Tocopherols	mg./100 ml.	107	104
Vitamin A	mcg./100 ml.	19	16
Thiamine	mcg./100 ml.	87	83
Vitamin B ₁₂	mcg./100 ml.	0.0022	0.0012

SUMMARY

These new findings help enlarge professional knowledge of the nutrient constituents of orange juice in general and add fresh evidence that, on a cost basis, MINUTE MAID Fresh-Frozen Orange Juice offers not only more Vitamin C, but also more of all the other vitamins and minerals listed.

Taken in conjunction with the previously published findings, this should confirm the choice of physicians who recommend MINUTE MAID in place of home-squeezed orange juice.

REFERENCES:

- (1) Rakieten, M. L., et al., Journal of the American Dietetic Association, October, 1951.
- (2) Joslin, C. L., and Bradley, J. E., Journal of Pediatrics, Vol. 39, No. 3, pp. 325-329 (1951).
- (3) Rakieten, M. L., et al., Journal of the American Dietetic Association, November, 1952.
- (4) Assn. Off. Agric. Chemists: Methods of Analysis, 7th ed. Wash.: Assn. Off. Agric. Chemists, 1950.

Reference #3 still available in reprint form.

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Wallace R. Roy, Ph.D., Director of Research





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To the Editor:

For many years it has been my pleasure, on behalf of the poliomyelitis patients, their families and the National Foundation for Infantile Paralysis, to thank the American nurses for their participation in the poliomyelitis patient care program. This year I would like to renew that expression of gratitude for the high quality of service rendered by all nurses who cared for the poliomyelitis patients or participated in the gamma globulin program during 1953.

However, appreciation is accompanied this year by a request for further assistance in reaching our goal in the field of poliomyelitis prevention. As you know, in 1954, the National Foundation for Infantile Paralysis in cooperation with Public Health Agencies is conducting vaccine field trials in many communities to assist in the evaluation of a poliomyelitis vaccine. These tests will be directed by the state and local health officers in the selected communities. Even though the health officer is primarily responsible, the success of these field trials will depend on the cooperation of all members of the health team volunteering

their services for the clinics to be held in the schools.

The National Foundation sincerely hopes that each nurse will respond to the community's needs with the same devotion and dedication to service that has justified the respect and honor the American people have for the members of the nursing profession.

BASIL O'CONNOR, PRESIDENT
NATIONAL FOUNDATION FOR
INFANTILE PARALYSIS, INC.
NEW YORK, N.Y.

Good Nursing Care

Dear Editor:

I have read *R.N.* almost since it was first printed. Recently I've read so many condemnations of present-day nurses that I would like to write a few words in their favor. I am an elderly nurse and this year I was a patient in a VA hospital for almost five months. The use of the 8-hour shift brought me in contact with many nurses, most of them recent graduates. The charge nurse was a World War II veteran and had recently earned her second academic degree. Of all these nurses, I can't complain of any just being "book" nurses. After my first operation, the surgeon told me he had done all he could, the success of his work de-

pendent on the nursing care I received. And I received such good nursing care that I was able to have a second necessary operation in record time. I never heard a nurse complain or fuss, and I wasn't what one would call a very good patient. The charge nurse also did lots of extra things for me when the others were busy. I asked her once why she didn't just let me wait for floor care. She replied that she loved nursing and always would like bedside nursing even if the administrator had made her a charge nurse. I shall never, never forget the wonderful care I had. If I had been a private patient with three special nurses, I couldn't have had better.

DORA GRAY, R.N.
SAUGUS, MASS.

Let's Speak with Dignity

Dear Editor:

Human dignity, subject of an article in the November, 1953 *R.N.*, means so little in so many instances. Yet is anything more important than the way we approach patients and how we conduct ourselves in a patient's room and in the nursing station? Recently I was working in a TB Sanatorium and I heard the afternoon supervisor remark to the superintendent at the dinner table that "The 'coons' on W. . . . wing ate their supper well." Imagine a person of that caliber holding a responsible position, and such a remark being countenanced by another in one more responsible! Do remarks like this add to the professional status of

women serving humanity of whatever race or creed? What do other R.N.'s think?

R.N., AKRON, OHIO

P.R. I.Q. Low?

Dear Editor:

In any emergency, the public may depend upon registered nurses to aid to the utmost. In every community, when nurses are needed because of disaster or to help in mass programs like this past summer's gamma globulin inoculations of children, they come by carloads to help. But are nurses understood? Do we not need better personal relations? And are the press and radio doing all they could to further better relationships?

Recently in North Carolina the nurses had a stiff fight to get a nurse practice bill passed by the legislature. There was a great amount of publicity, most of it favoring the bill, but enough against to give one serious thought. Some criticisms heard were that many nurses stop studying when they get their R.N., that nursing should be a dedication and no stress should be laid on long hours or little pay, that nurses often try to play doctor.

Is it wise to say nothing to refute these and similar criticisms, and thereby let the public assume we either do not care or have no rebuttal to offer? Or should we tell the public about the many fine young women who are taking degrees, doing postgraduate work, attending workshops, and studying eagerly to *make themselves better nurses?* Do



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tions do all they can to collect in-
teresting bits of news and get them
printed, or are they content to hold
office and do nothing, waiting for
their year to go by and another com-
mittee to be named? Many nurses
are actively engaged in religious,
civic, and political work in their
communities and are contributing
much to this work, while doing an
excellent professional job as well.
Shouldn't we see that the public
hears about their fine work, and
learns to know that women like them
form the true core of nursing?

(MRS.) **IONE B. BAIN**

GRANITE FALLS, N.C.

Appalling Attitude

Dear Editor:

You have been encouraging nurses
to speak up and air their differences
through the **R.N.**, so I'd like to ex-
press some of my opinions.

My husband is working toward an
advanced degree at a nearby Univer-
sity and the majority of our friends
are college and university people. I
have been appalled at their attitude
toward our profession; they seem
to consider nursing a mere technical
training not much above the level of
domestic help. Would this attitude
be partly responsible for our difficul-
ty in channeling high school gradu-
ates toward nursing? When will our
national representatives enlighten the
public that ours is truly an education
on a level with college work?

Also, why should former nurses be

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constantly dreading the knock on the door and pressure to go back to work? A mother's responsibility increases even when all of her children are in school—she frequently becomes involved in their group activities. Aren't we most needed at home? (MRS.) MURIEL HAWTHORNE, R.N.

NEVADA, IOWA

[We don't know precisely when our national organizations will map out a truly successful program for telling the public what nursing is, but we definitely believe that until the public learns, opinions like those cited here certainly will deter many from considering nursing. As far as the question of working mothers is concerned, we feel that this always has been and always should be an entirely individual decision. Home

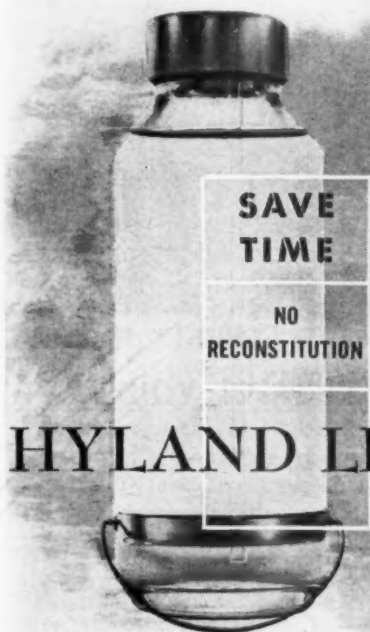
responsibilities are unquestionably great—it's up to the individual nurse to decide whether she can combine her family's interests and her own work satisfactorily. The most the rest of us can do is support things like child nurseries, well-planned shifts, part-time positions, etc.—THE EDITORS]

Doomed? Definitely!

Dear Editor:

Like the writer of the August D & C letter, I cannot help but feel "Doomed." The blame, as I see it, lies with the administrators of our hospitals and our doctors. How can they be so ignorant as to put their trust in not only practical nurses but even in housekeeping personnel?

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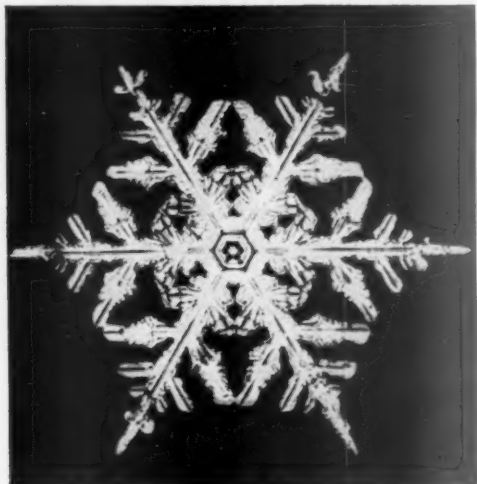
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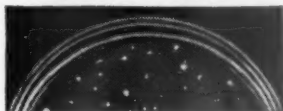


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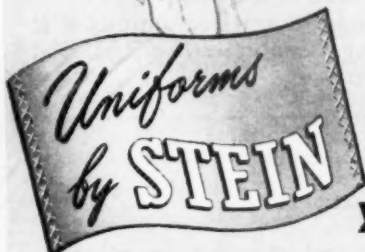


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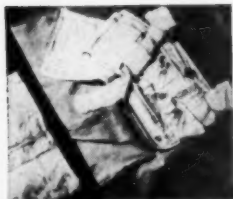
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PHOTOGRAPH BY RUZZI GREEN

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Powder contains boric acid, potassium alum, phenol, oil of eucalyptus, methyl salicylate, thymol and menthol.

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Administered at bedtime, CARBRITAL acts promptly to induce sound, refreshing sleep. Patients relax easily, sleep restfully, and awaken fresh and alert. In patients troubled by daytime tension or anxiety, CARBRITAL promotes relaxation and tranquility.

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Pentobarbital sodium	1½ grains
Carbromal	4 grains

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R541

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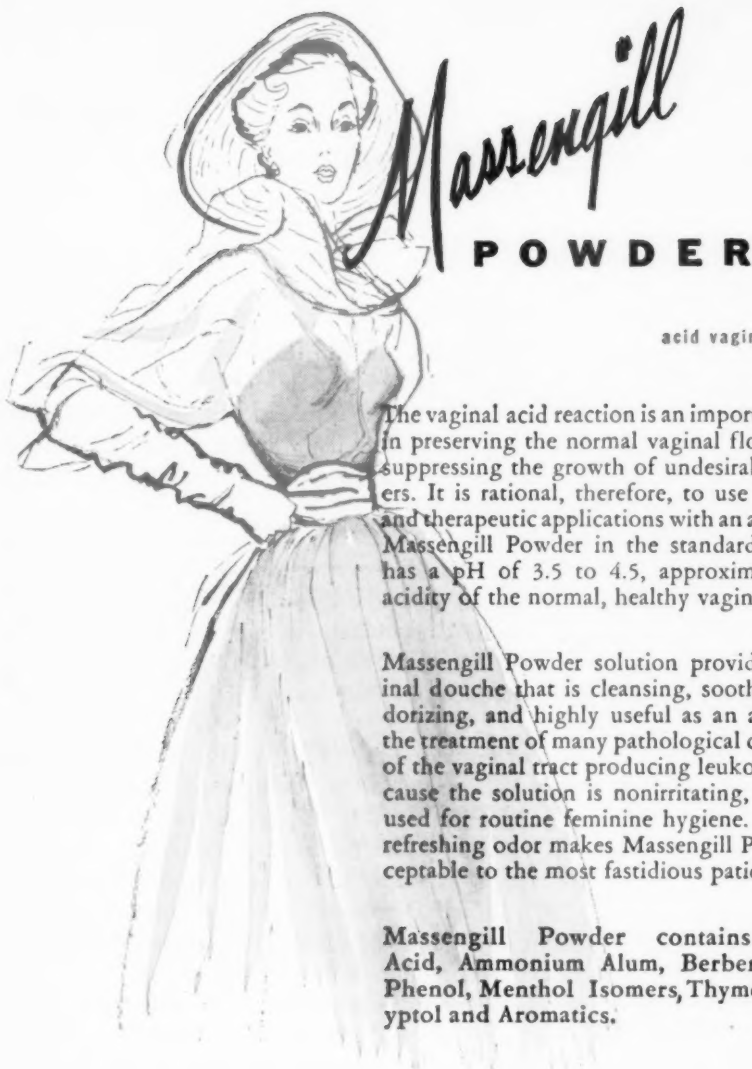
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Massengill Powder solution provides a vaginal douche that is cleansing, soothing, deodorizing, and highly useful as an adjunct in the treatment of many pathological conditions of the vaginal tract producing leukorrhea. Because the solution is nonirritating, it can be used for routine feminine hygiene. Its clean, refreshing odor makes Massengill Powder acceptable to the most fastidious patient.

Massengill Powder contains: Boric Acid, Ammonium Alum, Berberine Salt, Phenol, Menthol Isomers, Thymol, Eucalyptol and Aromatics.

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GENEROUS SAMPLE
ON REQUEST

Our "How to do it yourself" Programs

■ AGAIN ONE OF R.N.'s readers, in a letter to the editor, appears to have put an exploratory finger on a sensitivity that could easily be the core of our professional membership problems. In commenting on the September editorial, a Colorado R.N. wrote: "Our economic order has conditioned us to expect to pay money for service and to get service in exchange. We ask our professional members not only for money, but also for service—service which many times requires tools of a skilled profession other than nursing (collective bargaining, public relations, legislative lobbying). Perhaps nurses are not interested in buying 'How to do it yourself' programs, but feel that they are paying to have these programs supplied them."

R.N., Colorado poses us with the questions of how much of the activity of the professional organizations can be shifted from individual members to paid staffs, or where can the activity of the members who support the paid staff leave off and the paid staff's activity begin?

In the early days of our organizational history, all the secretarial and administrative work was done by volunteers. The first editor of the *AJN*, Sophia Palmer, already a busy administrator, edited the *Journal* from a suitcase under her bed. As activities increased, both in nurses' individual lives and in our professional associations, and as the need for a skilled approach to the handling of problems became more evident, it became mandatory to employ salaried help, but still to rely heavily on volunteer assistance.

The associations' paid executive secretaries had to learn by doing in a wholly unprecedented area. They had few guide lines. While they were learning what their jobs were and how to do them, the field was broadening, and the need for ever greater skill became all too apparent. The complexities required special skills—not possessed by nurse secretaries. Counselors, legal, public, and labor relations experts were employed, which brings us to the present dilemma.

Recognition of something as being a problem is sometimes the

first step in the solution. We must at this time recognize that as there is greater activity of the professional organizations, there should be a corresponding increase of the responsibilities on the part of individual members. Overworked committee members will shudder at this. But out of 175,000 members it should no longer be necessary (if it ever was) for one person to sit on two, three, and even four time-consuming committees. However, there is one basic principle underlying membership organizations that should be restated. Members, through their representative delegates and boards of directors, *should always maintain the policy-making prerogatives* of an organization. Though paid staffs may increase, members must not relinquish these policy-making responsibilities.

The paid staff has in the main a two-fold duty. The first is administration—carrying out the program activities set up by the governing bodies. That covers a lot of territory. No one who hasn't actually done the job can appreciate the enormous amount of detail that goes into the administration of an *active* nursing headquarters. The second duty is one of interpretation or public relations. It is another terrific job when handled correctly, for it entails work both within and outside the associations.

The members, however, have duties, too. It may be carrying on special projects such as when a district puts on a successful "door-bell ringing" membership campaign. The membership certainly has responsibility to serve on committees and boards, in assisting in convention administration, in reporting events and trends to headquarters, and in taking every opportunity to interpret nursing to the public.

The line between what should be done by the staff and what by the members cannot be a rigid one. Some states and districts can afford more paid staff than others. However, the work load of the district secretaries and treasurers in clearing and checking new members should be lightened. In an earlier editorial, we projected the idea that a financial allowance be given [Continued on page 76]

Some changes in nursing come with lightning speed; others, more gradual, are discernible only to the nurse who has watched the progress of the profession over a number of years.

Take nurses' living conditions, for example. To the veteran nurse who remembers the Spartan rules and furnishings of yesterday's nurses' homes, the gay, streamlined quarters of today represent a far more radical change than they do to the more recent graduate.

In both cases, though, the veteran and the young R.N. now accept the fact that comfortable, attractive accommodations are important adjuncts to their jobs. And most hospitals, spurred on by competitive attempts to secure nurses' services, give them high priority.

There is another side to the housing picture, too. As nursing has expanded into the community, and as work hours have been shortened, more and more nurses have chosen to live outside of the hospital. Consequently, today, in addition to nurses living in hospital quarters, we have nurses living on their own in homes, hotels, apartments, furnished rooms, and probably even in trailers.

Quarters supplied by the hospital seem to give R.N.'s a somewhat better break than their working sisters get in other fields. With housing as scarce and expensive as it is, most people find it difficult to get reasonably priced living accommodations, and no one helps them. But for nurses working in hospitals, there is an attempt to offer housing in or near



Evidence that residents of Ann Preston Hall

the hospital building itself. And there is the other advantage mentioned before: As hospitals put up new buildings, they seem to have the nurses' comfort more in mind than was usual some years back.

For nurses who prefer living in hospital-supplied quarters, there are two kinds of arrangements provided. One—the usual one—consists of individual rooms in a nurses' residence maintained and operated by the hospital. The other—a newer arrange-

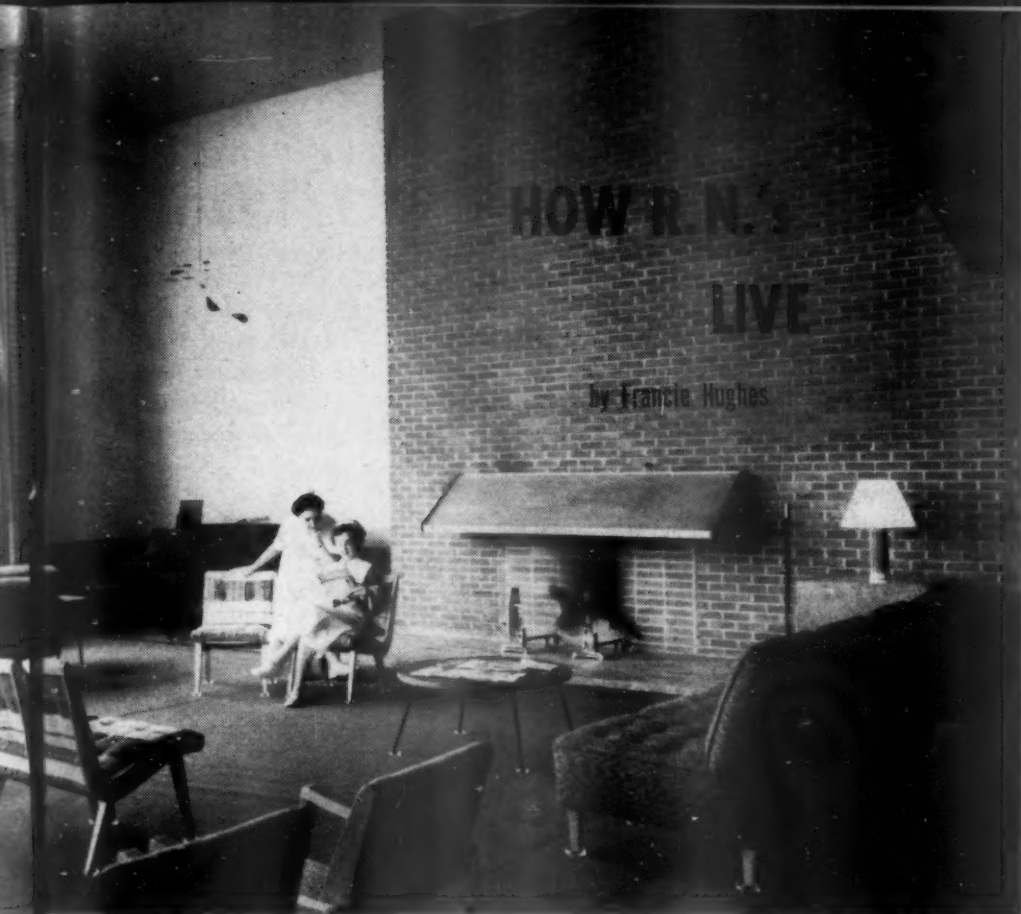


Photo: Condax Studios

Hal *live in the modern manner, this spacious two-story lounge impresses all who enter it.*

ment—is housing in hospital-maintained apartments of one or more rooms which form complete living accommodations.

The variety of accommodations for nurses who live on their own is so wide as to be infinite. One is the private apartment rented by one girl alone or by several who band together for purposes of economy and companionship; another is the hotel room. The others—rooming houses, women's residence clubs,

etc., are too numerous and too scattered for more than passing reference. Although these latter may house a large segment of the nurse population, they are too diverse to be mentioned in detail.

To find out how nurses generally solve their living problems, **R.N.** investigated four different kinds of living arrangements for nurses in four different cities in the East. Each arrangement is typical of many thousands of others, though no one is

typical of all or even a majority of the places that serve as nurses' homes. Naturally, there are unmarried R.N.'s who live at home with their families, and married R.N.'s who live at home with their husbands, but these are individual cases with individual housing solutions.

Living In, in New Jersey

The first hospital-provided quarters R.N. visited was an ultra-modern two-room and kitchenette apartment set-up for graduates in the newly-constructed Morristown (N.J.) Memorial Hospital's residence. This building, which was opened in July, 1952, stands in a neat, green park

across the lawn from the impressive new Memorial Hospital.

All the apartments in this modern residence have the same well-planned layout of two large rooms with picture windows facing a vista of green grass and trees—and a bath, kitchenette, and foyer which widens into a dining-alcove. Each room is equipped with a studio couch, tables, two comfortable, upholstered chairs, blonde wood desk and desk-chair, stream-lined chest, lamps and draperies in handsome, modern prints with sophisticated background colors like greige (grey and beige), cocoa, or charcoal grey. The inhabi-



Photos: Photocraft Studios

Convenience and comfort are key terms in any description of this apartment in the nurses' residence, Memorial Hospital, Morristown, N.J. Especially appealing is its modern, well-equipped kitchenette.





A feature of many of the apartments in Harkness Hall, Presbyterian Hospital, New York City, is a picture window through which a fascinating view of the majestic Hudson River can be seen.

Photo: F. M. Demarest



tants have a choice of treating both their rooms like bedrooms, or sharing one bedroom and turning the other room into a living room. The foyer-alcove usually contains a dining table and chairs.

Because the hospital's nursing director, Ruth Anderson, loves to cook and entertain, she insisted on good stoves in the kitchenette, "so the girls can roast a chicken if they want to." There are four-burner ranges with ovens and broilers, also stainless steel sinks, Formica counters, closets, electric outlets for toaster and percolator—and a vent with a good draft for carrying off kitchen bou-

quets before they linger overlong.

Morristown Memorial provides and launders all bed-linens and uniforms, but both wings of the residence and the basement have well-equipped laundries where nurses can wash personal things. Naturally, the residents provision their own apartments. However, they may eat in the hospital cafeteria if they prefer. The same decorators who chose such cheery colors for the walls, draperies, upholstery, and lamps of the hospital, the residence, and the clinic (usually a dreary place where patients put in waiting time), also decorated the hospital cafeteria in

light bisque, lemon yellow, and grey, making it an inviting place for meals.

The hospital, staffed entirely by graduates, considers it a convenience to have the nurses in residence on the grounds, so the girls get their full salaries in cash, with minimum deductions for rent or food. "Living conditions are so pleasant in the Morristown Memorial nursing residence," says Miss Anderson, "we lose our nurses to only one rival: Dan Cupid, for there are no apartments for married nurses."

Across The

George Washington Bridge

Now to Manhattan and a 12-story cliffside apartment house overlooking the Hudson River—the Edward S. Harkness Memorial Hall. Here, 200 R.N.'s on the payroll of the Presbyterian Hospital live in apartments decorated in true modern style.

Harkness Hall has fifteen apartments to each floor, and there are, altogether, 104 single apartments, sixty-three two-room apartments and thirteen three-room units. Usually, two nurses share the two-room apartments, though they needn't if they can swing the rent alone. Rentals are deducted monthly from hospital salaries as follows: for one-room and kitchenette apartments, \$32 to \$35; for two rooms and kitchen, \$60; for three rooms and kitchen, \$80.*

The typical two-room apartment plus kitchen, at \$60 a month, has a river view on one side and faces a semi-circular park on the other, across from the Medical Center. The

*The author or editors are not responsible for any rent increases since date of interview.



14 x 16 foot living room has two big picture windows hung with Venetian blinds, and the bedroom also has a picture window to take advantage of the view.

Streamlined modern furniture decorates the apartments, and handsome draperies and a good rug are provided by the hospital. Every living room has an upholstered couch, two easy chairs, a coffee table, end table, three straight-backed chairs, and a combination chest and bookcase. The bedrooms have modern draperies, fine rugs, Venetian blinds, comfortable beds with light wood head and footboards, a dressing table, easy chair, chest, bedside table, lamps, and plenty of closet



Marie Kelly and Pauline Doner engage in favorite pastimes in the living room of their New York apartment. On the left, and two steps up from the living room, is the dining area.

room, always wished for, seldom found.

The one-room units have Simmons hide-a-beds that look like upholstered sofas, so-called Murphy kitchens behind louvered doors, and, last but not least, extra large closets. Walls are painted in Wedgewood blue, pale green, or pale yellow, and the furniture is finished in blonde mahogany veneer. Easy chairs are upholstered with foam rubber typifying the last word in the appointments of these apartments.

Guests may come and go as they please at this apartment building, but for big parties, residents usually avail themselves of the huge general living room on the main floor which leads into a wide terrace overlooking

the Hudson. This is wonderfully inviting on summer evenings when the terrace furniture is in place. This gracious living room is furnished with a grand piano, and circular couches, upholstered in modern colors flanked by handsome, harmonizing lamps. There's a kitchen adjacent, too, for rustling up food for a party.

The basement houses a tremendous laundry for residents, used also by the student nurses from Maxwell Hall next door. The average New York apartment house does not take telephone messages for its residents, but Harkness does, and also provides phone booths for outgoing calls, though residents may install

their own phones if they like. R.N.'s may cook in their own apartments, or they may eat in the hospital's cafeteria, the latter at their own expense. Only student nurses, interns, and some of the resident doctors have free meal tickets.

Harkness Hall has proved so popular with the staff that facilities have had to be expanded. Now the hospital has part of a housing development in Fort Lee, N.J., just across the George Washington Bridge, to take care of the many requests for apartments. Small wonder that neither Harkness nor the Fort Lee apartment houses ever get to hang out that little sign for which New Yorkers have to hunt so desperately—"Vacancy."

Via The Turnpike

Philadelphia's Ann Preston Hall, the new nursing residence of the Woman's Medical College of Pennsylvania, is a beautiful, modern brick and limestone structure, fronting on a broad lawn and overlooking a river valley. Its spaciousness impresses you as first you set foot inside its inviting two-story lounge—a lounge that has, at one end, a floor to ceiling fireplace with a copper hood over the hearth; at the other, a sweep of windows. Hung with modern, fibre glass draperies shading from pale rose to silver-blue to mauve, these windows, subtly tinted, actually are an entire glass wall that soars from floor to ceiling. For dramatic accent, the rug is jade green; coffee tables are of blonde wood, and sofas are upholstered in vibrant turquoise. In a niche beyond the fire-

place stands a grand piano, and hung from the ceiling swings a modern mobile. The room is sprinkled with lamps, inviting reading. Off the big lounge is an alcove for card parties. Food for parties can be served from a small adjoining kitchen, and a dumbwaiter also carries food downstairs to a game room where there's another piano, a ping-pong table, a television set, and other recreational equipment. Two flat decks on top of the building are designed to encourage sunbathing.

The first consideration in planning this colorful residence was for privacy, so important to nurses who sleep and work at unusual hours. For this reason, all the rooms are single rooms. The residence is divided into two wings, one for graduate nurses and the other for students. All rooms are alike with the same basic equipment—Venetian blinds, a studio couch with blonde wood ends, blonde wood desk and chair, upholstered chair, a student lamp, another lamp, and a built-in unit which combines chest, lavatory, and dressing table. Walls are tinted white, pinky beige, pale blue, or mint green, and the occupants of the rooms may accent them with their own draperies if they like. Both wings of the residence have a complete laundry with electric washer, dryer, and ironing boards. Each wing has its own smaller lounge, too, with comfortable furniture, an electric stove, ice box, and cupboard. Here the nurses gather informally for late snacks, or to cook breakfast if they want to sleep [Continued on page 69]

CANDID

COMMENTS:

Marks of a Profession

■ There is no greater single need before us than that we understand the place of the nursing profession beside other professions in meeting the health needs of the American people. I believe greatly that such an understanding on the part of the group as a whole is one of the marks of a profession. The majority of us, not just a handful of leaders, must realize that nursing has moved into a place of dignity and worth on its own merits; that it works with but does not lean upon other professions; that it has its own literature, its own principles and procedures, its own ethical code and traditions, and its own way of life.



Janet M. Geister, R.N.

Recognition of this kind involves other recognitions. We must recognize that the increased stature of the profession demands increased stature from its members—a greater sense of responsibility to the profession and its purposes. We must recognize that as we have moved outward to people and assumed greater obligations for their nursing care, we have incurred losses in morale and quality of service that must be overcome. We must recognize that in reaching toward higher goals in education and practice we dare not underrate the intrinsic educational and character-building values that are distinctively a product of the practice of nursing.

As a group, we must realize that we have earned a distinct place among the health professions, and that this carries not only new obligations but also the right to speak with authority on all situations that pertain to nursing care. As stated last month, we can no longer in conscience passively accept the demoralizing overloads of work that follow when we have no voice in overall plans and policies for patient care. Until we know our place, we cannot, as a group, learn how to meet with others, talk with them, listen to them, and argue things out objectively so that finally we find the points of agreement of profit to all concerned. Until we recognize our own distinctions and give less heed to the patterns established in other fields, we cannot truly evaluate and cling to the qualities in service that have built the profession.

A profession stands on its own feet, ready and eager to recognize the place of others and to cooperate with them—but leaning on none. Our relationship with the medical profession is different from that of any other two such groups, yet we have reached a point where we must more clearly recognize our own obligations. It took decades to separate the nurse from her "handmaiden-to-the-doctor" identity. A

lot of water has gone over the dam since those days. Progressive doctors are among the first to agree today that nursing and doctoring are two wholly different things, interdependent, yet also independent. But nurses seem to be slower to recognize this.

In the years before nursing took concrete shape, we borrowed heavily from the doctors. They gave generously in time and knowledge to teach us in classrooms and to lecture in our meetings. They still do. They wrote many of the articles in our early publications that preceded our own text books. They helped us learn new medicines and new methods. Today, as was pointed out earlier, we have our own literature, our own procedures, even our own vocabulary. Yet the habit of borrowing and of leaning is still strong. Nurses have a great deal to teach each other out of their varied experiences, but for every nursing lecture we have on our district programs, for example, we have from six to a dozen medical lectures. It is not that we should appreciate less what we can learn from doctors, but that we need to appreciate more the knowledge that we ourselves possess.

One of our most urgent tasks in this era of overwhelming case-loads is to work out policies with the doctors that would lead to a more equitable load for the nurses, and enable them to concentrate on greatest needs. But the "Yes, Doctor!" tradition still lingers. It would benefit us both if we would develop a new tradition of "Yes, Doctor, but . . ."

What are the marks of a profes-

sion? A good many wise people have worked out various definitions that appear commonly to stress three qualities: specific, scientific preparation; the establishment of a code of ethics that underlines basic principles of conduct; and a "spirit of increasing altruism." For the "helping" professions, altruism, which is "a regard for and devotion to the interests of others," must forever remain at the top, otherwise the profession loses in value and distinction.

In our efforts in nursing to meet our growing obligations, not only in volume but in quality, a great deal of stress has been placed upon the need for college degrees. We are

"Zeke
& Dessie"



gravely short of nurses qualified to take the thousands of new administrative positions that have opened as nursing broadened its frontiers. Further, today's ministrations to the patient must be against a background of his mental, spiritual, economic and social as well as his physical needs. No one can doubt our need for more and still more education.

But in nursing as in all young professions, the tendency has been to value the degree rather than to evaluate what its acquisition has given to its possessor. Has it deepened her insight, her understanding of people? Has it taught her how to think—given her a philosophy that enables her to

develop the best in her staff members? Or has it simply filled her head with a mass of scientific facts that may take years, if ever, to be digested and to be brought into usefulness? Getting a degree under today's system is no guarantee that one has been educated.

The stress on degrees has dampened the ardor of many worthy nurses unable to attain them. These nurses are naturally worried about their own opportunities, but they are also worried for the profession. They fear that the zeal for degrees blinds some of our authorities to the educational values that lie in the practice of nursing itself. We veterans learned



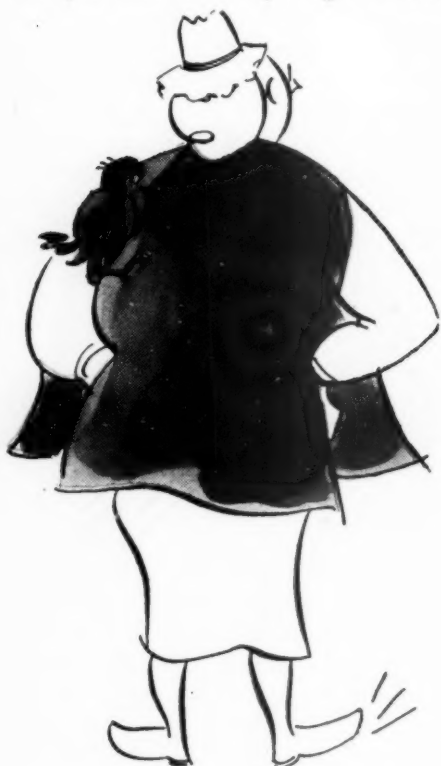
things decades ago about people, their troubles, and their behavior under stress, that no course in psychology or sociology has ever replaced. A private duty nurse tells how her heart case was restored through this nurse's patient and intelligent work in helping the patient's daughter overcome alcoholism. An industrial management official tells that his nurse has won the deep affection and respect of everybody in the plant because she has "restored" so many skilled workers whose emotional or physical failures were disqualifying them. These nurses—and their counterparts are everywhere—had only high school

preparation. They acquired their skills, judgments, and knowledge of people by being nurses.

A profession like nursing cannot fully be measured by its percentage of academic degrees. Altruism in nursing implies *service*—putting our knowledge and ideals to work for others. The quantity of our knowledge must be matched by the quality of our service—and service involves many things. It calls for the high resolution of nurses who understand where they are going and who participate in the going; the high resolution that is built on faith in our purposes, and confidence in each other and pride in what nursing is doing. We cannot build up a true professional attitude among nurses who have either lost their faith or are unaware of their place in the sun. The poor nursing that is increasingly coming into public notice^o is due not primarily to poor procedure training but to wrong attitudes. Wrong attitudes have their roots in *some* cause, and it is folly to brush off the complaints of poor care as "isolated instances." They are symptoms that must be examined, symptoms of lost faiths or frustrations.

Some of the disaffection is undoubtedly due to nurses living in semi-darkness as to the meanings of the changes—the separation of the nurse from her patient, the introduction of non-professional workers. The changes have been too radical and too sudden. We are just beginning to learn in [Continued on page 82]

^o"Must Our Hospitals Terrify Children?" *Readers Digest*, Jan. 1954.



MORE THAN TECHNIQUE



Considered offhand, there was nothing to choose between the two nurses. Each wore the cap and uniform; each had had experience. Even in physique and complexion they were not dissimilar. Nor was there any choice in mere digital skill: when either one smoothed the bed or fixed the pillows, there was a gain in comfort. Either could arrange a tray of invalid food so that it looked appetizing. They both had plenty of good hard muscle too, and could lift a patient up in bed or give an alcohol rub as easily as you pick up your hat. Compared on paper, one nurse was as good as the other. But actually, in their effect on the patient, they were worlds apart. For "A" did her work as if it were a joy; "X" went through it as though it were mere duty. "A" took her patient's pulse as if that were a great lark; "X" as if she were reading a seismograph. "A" made you feel that you weren't doing your part unless you hurried up and got well; "X" gave the impression that so long as she was faithful it didn't matter when (or if) you recovered. "X" was every bit as hard-working and conscientious as "A." But "X" was only a girl who was following the trade of nurse; whereas "A" was primarily engaged in using her skill as a nurse to do something for somebody else. "A" had something more than a graduate's diploma; she had discovered one of the biggest secrets of life.

— Source unknown

Alta Bates—
**COMMUNITY
HOSPITAL**
and
NURSE

by Genevieve Schneider

■ "HOW DID YOU ever manage to build this big hospital?" visitors often ask Alta Bates, the founder of the Alta Bates Community Hospital in Berkeley, California.

"Oh, it just grew, bit by bit," she answers, "and now we're completing plans for another wing." Now in retirement she still has a strong suggestion in her voice of the determination which helped carry her through almost fifty years of the hospital's

subsequent growth and development.

Alta Bates Community Hospital has become such a well-known institution that many people do not always associate the name of the hospital with the gentle lady with the quiet, dark eyes. But most of the old-time residents of Berkeley are well acquainted with Miss Alta Bates—the nurse. And some remember when she arrived in Berkeley with her parents and brother in 1904,



shortly after her graduation from Eureka Hospital. It was then, while she was in her middle twenties, that she advertised in the *Berkeley Gazette* that she would accommodate a few patients in her home. A year afterward, she started her training school with six student nurses.

After the earthquake and San Francisco fire, Alta Bates opened her doors to refugees, and soon the small building overflowed. There was only one way to house the increasing number of patients—and that was to build a hospital. Fortunately, the young nurse's pioneer spirit was strong. It was also evident that she had plenty of creative and executive ability besides being a good nurse who was able to impart her knowledge. "She's bound to win!" doctors and business men prophesied, when they heard of the hospital venture. And she did. But she found it far from smooth sailing.

Having little money of her own, Alta Bates supplied the ideas while her father supplied the finances. Luckily, her dad was a contractor and builder by trade, so together they pooled their resources. The first problem on their list was to find a desirable location. Berkeley was then a small college town, its rolling hills covered with oak trees and grass, its fields bright with California poppies and wild pansies. While exploring the neighborhood one afternoon, they found the ideal spot, overlooking the Golden Gate. But it was already marked off for a residential area. Stopping to talk with a man who was stacking lumber, they dis-

covered that he was the owner of the property. It didn't take long for Alta Bates to sell him her idea, and soon the first wing of the hospital went up on the corner of Webster and Regent Streets. Within a year another wing followed.

It was about this time that Alta Bates discussed her plans with a young man by the name of Lester Hink, whose father was owner of Berkeley's largest department store. Mr. Hink, now a top business executive and philanthropist, and one of the trustees of the hospital, recalls that his first impression of Alta Bates was of her sincerity and desire to serve the community. "We were only too glad to extend credit to such a person," he says. So, it was with linen and blankets from Hink's, that the beds were made ready for the new patients.

From the first, Alta Bates realized that her hospital must gain the good will of the community. One of the doctors, always fastidious, brought his equally fastidious patient, a lady who had tried every hospital in San Francisco, to Alta Bates—hospital and nurse. There was scarcely enough money on hand for the plainest food, but when the patient ordered squab on toast, Miss Bates couldn't afford to displease her. This willingness to serve even squab on toast earned the hospital an early reputation for delicious meals. And, even today, many a busy mother looks forward to her confinement at the Alta Bates Community Hospital as a vacation.

The sympathetic understanding

which Miss Bates gave to all her patients and employes was probably felt most by her nurses. Many of them count the three years under her supervision as the most important character-building years of their lives. The 226 nurses whom she graduated really understood the meaning of the words, "Non Nobis Solum,"* which were engraved upon the gold shields of their pin.

During the flu epidemic of 1918, the nurses realized Alta Bates' strength when she came on duty and worked along with the staff. Patients were arriving and dying so fast that there was scarcely time to prepare a room for the next case. Two-thirds of the nursing and medical staff were in bed with flu or pneumonia, the laundry workers were few and far between, and Ling, the Chinese cook, was barely able to keep going. But Miss Bates walked calmly onto the third floor with a huge yellow mixing bowl from her own kitchen. She loved to cook—was always making jams and jellies. But in that flu epidemic the bowl had a different use, for the doctors' orders read, *sinapism q 4h*. So she mixed mustard paste, and as soon as it was spread on gauze, wrapped, and placed on a tray with a hot water bag, it was dispatched to patients while she stirred up another batch. One after another as the nurses came back on duty, walking unsteadily into the chart room they would find Miss Bates there, ready with a bottle of Scott's emulsion to build up their resistance.

After the flu subsided, the hospital

**Not Ourselves Alone*


was still crowded. When the Armistice was signed, the boys came home, and with an influx of new families, Berkeley started on a building spree. The consultation rooms and even the halls of the hospital were used to accommodate patients.

Miss Bates had plans drawn up for a new building. But since it would take all of her savings and more, a corporation was formed which lasted until 1946. The plans specified that part of the old hospital would be destroyed to make room for a larger structure and that the old part would be rebuilt for laboratories and a nurses' recreation room.

Before the old building was torn down, Miss Bates invited the nurses who had trained there, with some of the doctors and friends, to a short program in its honor. The Reverend Cross, present mayor of Berkeley, who had greeted his own six babies for the first time at the institution, spoke in honor of the occasion.

In 1928, when the new building was finished, the city authorities closed off the street and allowed chairs to be placed there for the dedication ceremony. But there were few in the crowd who dreamed that the depression was just around the bend; and it wasn't long before Alta Bates was almost swamped by her creditors.

Mr. Hink remembers the crisis well. "One evening," he said, "while visiting a friend of mine in the hospital, Miss Bates stopped in on her usual round of calls, and I asked her if she were ill. Her eyes had great dark circles [*Continued on page 78*]



The Heedless Herpes

by Herman Goodman, M.D.

■ IT ALWAYS happens! A date, particularly with a new friend, and a group of fever blisters appears on the lips. Without a sign in advance, clear water blisters—tiny vesicles—appear on a small area of reddish skin or lip mucous membrane. The individual subject to fever blisters usually has them each summer, or each winter, or twice a year, or once a month.

The fever blister, a misnomer, has little if any connection with fever, although it is true that some few diseases have been preceded by the appearance of cold sores or fever blisters. On rare occasions, very severe inflammations of the nervous system are associated with the appearance of annoying cold sores or fever blisters.

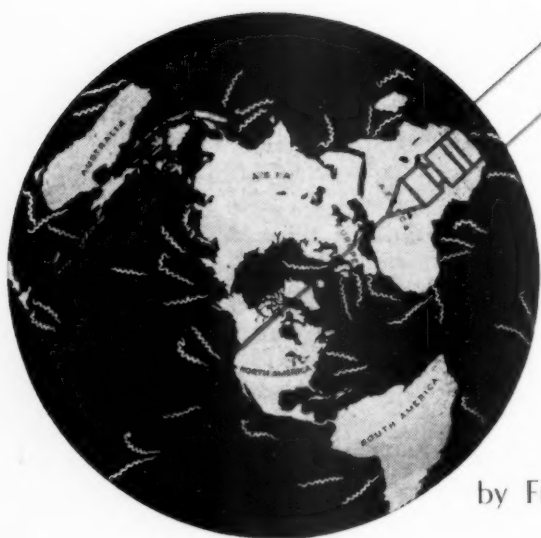
A cold sore or simple herpes of the lip and face is due to an infectious agent, a virus. Some contend that cold sores appear during periods of emotional or mental stress, reasoning that the virus is able to gain a foothold at such times. Many women have come to consider cold sores a

necessary evil during menstruation.

An eruption very like simple herpes becomes manifest in some each time a particular food or medication is taken. Cold sores may also appear after exposure to intense sunlight. The recurrent form of herpes simplex apparently attacks the same area each time the blisters appear.

Initially, the small blisters contain clear fluid. If they persist, the fluid will become purulent, and should the fever blister break, an adherent crust will form which may be followed by a superficial ulcer. By and large, cold sores heal without scarring, but infection and rubbing may destroy some of the true skin. Then healing must be with a scar. Ordinarily, each attack of herpes simplex clears in a period of five or ten days.

The attempt must be made to prevent new crops of fever blisters. Unfortunately, no specific is available. A few physicians utilize repeated smallpox immunization techniques but the results are not certain. Preventive measures, care of the teeth, tonsils, and [Continued on page 74]



SYPHILIS

today

by Frances Lewis Elder

■ HISTORIANS DISAGREE as to the original source of syphilis. Some contend that the scourge which spread throughout Europe with such virulence in the Middle Ages was a new disease brought from the island of Haiti by the men who sailed with Columbus. Others attribute the European epidemics to the sudden flaring up of an old disease inherited from antiquity. But whatever its origin, there is no disputing the fact that ever since syphilis was first described in the sixteenth century, it has continued to plague mankind.

The unpleasant truth that syphilis is still a modern-day problem in the U.S., as well as in other parts of the

world, was brought home vividly by selective service statistics of World War II, when it was found that more than 4 per cent of the draftees examined were syphilitic. Other estimates, based on U.S. Public Health Service surveys, have shown that approximately 500,000 new infections with syphilis develop every year in this country.

There is a brighter side to the syphilis picture, though, that cannot be lost sight of. And this is the progress that science and health education have made in recent years toward the eradication of the disease. Better methods of treatment, more effective case finding, including

blood tests, and more general recognition of the disease as a public health menace, have all contributed to the decline of syphilis. Another important factor is a more enlightened public attitude toward venereal diseases in general. Once the taboo words of polite society because of their association with sexual promiscuity, syphilis and gonorrhea have emerged from the veils of Victorian prudery as subjects that can now be discussed with a fair amount of clinical objectivity. Public health, after all, is not concerned with people's morals; it is primarily concerned with safeguarding the people from the ravages of a destructive disease.

How destructive syphilis really is can be seen in those patients who have received inadequate treatment or no treatment at all in the initial stages of the disease. For to be successful, syphilotherapy must be based on early recognition of the presence of the causative organism in the body. It is believed that syphilis can be checked in almost 100 per cent of cases if it is treated early and vigorously, and also followed carefully. Moreover, it is possible to prevent congenital syphilis even though the disease of the mother is not detected until as late as the seventh month.

Discovering the disease in its primary form, however, is frequently difficult. Although there is generally a primary lesion or chancre at the point of invasion of the spirochete, this may be overlooked by the victim or believed to be an annoying pimple. Furthermore, the blood test does not become positive until sev-

eral days or weeks after the appearance of the chancre. The main diagnostic evidence during this period is derived from a darkfield illumination of material from the chancre. Using this method, it should be possible in the majority of cases to demonstrate the corkscrew-like spirochete of syphilis—*Treponema pallidum*.

The infectiousness of the *Treponema pallidum*, which is easily killed by drying and the use of soap, depends on its being transmitted from one moist surface to another. It is estimated that approximately 90 per cent of syphilis cases are acquired through sexual contact. The remainder are transmitted by kissing, transfusions of infected blood or plasma, and, less commonly, by contact with contaminated objects such as drinking cups, douches, and rectal tips. Syphilis is also transmitted through the placenta from mother to fetus, and doctors, nurses, and dentists may accidentally acquire the disease through exposure to infectious lesions.

The typical chancre, which appears about twelve to forty days after initial contact, is a red papule whose surface gradually becomes eroded until it measures about 0.5 to 2 cm. in diameter. It is generally painless and heals slowly in about three to eight weeks. Chancres may be found in the genital region and on the lip, tongue, pharynx, thigh, and female breast, or they may be hidden in the urethra, the cervix, or the posterior vault of the vagina. Other signs and symptoms of the spirochete invasion may be swelling

of the lymph nodes, fever, malaise, lack of appetite, and mild aches and pains.

In the secondary stage of early syphilis, after the spirochetes have spread through the tissues of the body, the predominating signs are skin and mucosal lesions with most of the skin eruptions appearing in either macular and/or papular form. Mild systemic symptoms at this juncture, which may or may not be noticed by the patient, include headache, malaise, nausea, vomiting, iritis, tinnitus, vertigo, deafness, and hoarseness. There may also be a general lymphadenitis. A positive diagnosis can usually be established in secondary syphilis by serologic tests (positive in about 99 per cent of secondary cases) and by dark-field examination of scrapings from papular, genital, anal, or lip lesions.

Following secondary syphilis there is a latent period in which the presence of the disease can usually be detected by serologic tests only, for there are no clinical manifestations. This phase in the syphilitic sequence of events, which may extend anywhere from a few months to a lifetime, is generally divided into a potentially infectious stage—early latent, and a non-infectious stage—late latent. The early latent period refers to the four-year period immediately following infection.

It has been stated that when early syphilis remains untreated, "the probable outcome after five years will be a division of cases into four groups of approximately 25 per cent each: spontaneous 'cure,' latent syph-

Science Shorts

In a study reported in the *Journal of the American Dental Association*, dental x-rays were taken without the use of an x-ray machine. Doctors Harry D. Spangenburg, Jr. and M. L. Pool utilized certain radioisotopes which acted as sources of radiation like that produced by dental x-ray equipment.

■

Prominent among the drugs discussed at the symposium on antibiotics, sponsored by the Department of Health, Education and Welfare, was tetracycline (Achromycin), a new wide-spectrum antibiotic noted for its low toxicity. Its action is similar to Aureomycin's.

■

A new drug, Serpasil—the crystalline alkaloid of the Indian herb *Rauwolfia serpentina*—has been used successfully for the treatment of hypertension. The drug seems most valuable when given to patients with superimposed emotional disturbances; it produces a feeling of calm and relaxation due to its depressant action on the hypothalamus.

■

A paste of dried blood plasma and Peruvian balsam has caused rapid healing when applied to ulcerated bed sores, Doctors A. Bernice Clark and Howard Rusk report in the JAMA. The paste is especially beneficial in the presence of dead tissue and infection.

■

Life-expectation for diabetics has greatly increased, the Metropolitan Life Insurance Company reports. Statisticians have found that no less than 35 per cent of recently deceased persons, formerly treated at Boston's Joslin clinic, lived for twenty years or more after the onset of diabetes and that the causes of death resemble more and more the causes found among non-diabetics.

Now available as a ready-to-eat cereal or flavorful food-enricher is a prepared wheat germ. Wheat germ, removed in the processing of flour, has been recognized by the Council on Foods and Nutrition of the AMA as a good source of high quality proteins, thiamine, and various other nutritives.

■

According to the USPHS, 85,607 active or probably active cases of tuberculosis were newly reported in 1952—an annual rate of 55 per 100,000 population. A total of 109,837 cases were reported for continental U.S., 7 per cent less than the 1951 total.

■

A disease which sometimes results in blindness and is caused by infection with small threadlike worms now affects about 20 million persons, 19 million of whom are in Africa, WHO reports. Known as onchocerciasis, the disease is transmitted by certain species of flies and may cause skin rash and small tumors as well as eye lesions.

■

Contaminated crushed ice is often the source of water-borne disease, a JAMA editorial points out, while recommending the addition of a chlorine solution to the ice container. No flavor of chlorine is imparted to the iced drinks yet the bacterial count is reduced.

■

Two St. Louis blood experts have suggested that it might be better psychologically, as well as more expedient, for blood donors to sit up rather than lie prone. In tests involving 190 donors—85 in the upright position and 105 in the usual position—Dr. R. O. Meuthner and B. Koster, B.S., observed no appreciable difference in blood pressure, pulse, or reaction incidence in the two groups.

ilis, gummatous lesions, and cardiovascular or neurosyphilis.”*

The lesions of late or tertiary syphilis generally appear about three to five years after the chancre and differ from those of the early stages in that they are chronic and destructive and always heal with scar tissue. The so-called gummata that are found in the late stage are believed to be allergic reactions due to tissues that have become hypersensitive to *Treponema pallidum*. It is difficult to find spirochetes in these late granulomatous lesions.

None of the tissues of the body are exempt from the late lesions of syphilis but the most common sites of involvement are the skin, bone, liver, mucous membranes, the eye, and the heart and great vessels. A characteristic sign of syphilitic bone lesions is the “saber shin” or periostitis of the tibia where there is a formation of new bone. Sometimes, in active, hidden syphilis, where there is a low grade process of fibrosis, no lesion is suspected until important structures such as the aorta have been dangerously weakened by fibrosis or by destruction of tissue. Cardiovascular syphilis is one of the most serious conditions of late syphilis.

Another dreaded manifestation of late syphilis is the involvement of the central nervous system or neurosyphilis which may lead to the development of tabes dorsalis (locomotor ataxia) or general paresis. Another form [Continued on page 65]

*The Merck Manual of Diagnosis and Therapy, p. 1424.

Drug Digest



PENICILLIN G. PROCAINE U.S.P. (Antibiotic)

PRODUCT NAMES: Distributed under official name.

PHARMACOLOGY: Penicillin is now by far the most effective drug in the treatment of syphilis by virtue of its low cost, short period of treatment, and ability to produce a therapeutic response in such a large number of cases. Because the relatively insoluble and slowly absorbed penicillin salts like procaine penicillin maintain a more prolonged blood level of penicillin, their use is generally preferred in syphilotherapy. Although penicillin produces its most dramatic effect in early syphilis, it is also used successfully in the management of late syphilis.

DOSAGE: Penicillin dosage varies according to the individual patient and the stage of the disease, but the tendency is to give larger single doses than in the past. The addition of aluminum monostearate to procaine penicillin delays the absorption and excretion of penicillin.

UNTOWARD ACTIONS: As clinical experience with penicillin increases, there are more reports of untoward reactions such as urticaria, fever, skin eruptions, pruritis. In syphilis therapy, penicillin is discontinued in moderate and severe urticaria or angioneurotic edema of the upper respiratory tract. The most common reaction of syphilitic patients to penicillin therapy is the Herxheimer reaction which can also occur with other forms of specific therapy. Related to the massive destruction of spirochetes in the lesions and blood stream, it is marked by fever, aggravation of lesions, headache, malaise, weakness, and a chilly sensation. Therapy is discontinued only when the reaction is unusually severe or threatens to be fatal.

OXOPHENARSINE HYDROCHLORIDE U.S.P. (Antisyphilitic)

PRODUCT NAMES: Mapharsen.

PHARMACOLOGY: The organic, trivalent arsenical, oxophenarsine hydrochloride, has been used clinically in the treatment of syphilis since 1932. Until the introduction of penicillin, it was the antisyphilitic of choice because of its low toxicity and relatively constant parasitocidal action. In early syphilis, particularly, it is promptly effective, causing the disappearance of spirochetes, the healing of lesions, and the reversal of positive serologic tests in a large number of cases. Although at the present time this arsenical has been largely superseded by penicillin, it is still used by some clinicians in cases of treatment failure with penicillin.

DOSAGE: The initial I.V. dosage is 0.03 Gm. for women and 0.04 Gm. for men. Since the drug is quickly excreted by the kidney, injections may be given every four or five days. Rapid injections are preferred for these are less apt to produce pain in the injected arm. Dosage schedules, which are on an individual basis, often include injections of bismuth as well as penicillin.

UNTOWARD ACTIONS: Gastro-intestinal reactions may be decreased by withholding food for three hours before injection. The most frequent untoward symptoms are nausea and vomiting, lacrimation, and pruritis; blood dyscrasias, dermatitis, and jaundice are rare. The presence of hepatitis or kidney damage generally precludes the use of arsenicals. In severe reactions resulting from arsenic poisoning, the prompt use of BAL is indicated.



BISMUTH SUBSALICYLATE INJECTION U.S.P. (Antisyphilitic)

PRODUCT NAMES: Distributed under official name.

PHARMACOLOGY: The preparation of bismuth most commonly used in the treatment of syphilis is bismuth subsalicylate in oil. As an antisyphilitic, whose therapeutic value lies between that of mercury and arsphenamine, it has been given in syphilis as an adjunct to the arsenical drugs, chiefly oxophenarsine hydrochloride. With the advent of penicillin, alternating courses of oxophenarsine and bismuth are chiefly reserved for those cases of syphilis which are refractory to penicillin. In cardiovascular syphilis, bismuth injections may be given prior to administration of penicillin in order to reduce the chance of a dangerous Herxheimer reaction, or therapeutic shock, which results from an abrupt and massive destruction of *T. pallidum* in the lesions and blood stream.

DOSAGE: Bismuth subsalicylate is given intramuscularly rather than intravenously because of the narrow margin between therapeutic and toxic dosage. The average adult dose is 0.1 to 0.13 Gm. given at five- to seven-day intervals in courses of 6 to 12 injections. The I.M. injection is made in the upper outer quadrant of the buttock with the patient in a prone position with feet toed in to produce relaxation. Care should be taken that the needle does not enter a vein or artery for serious embolic complications can follow careless injections.

UNTOWARD ACTIONS: Side effects from bismuth injections are rare except for stomatitis which is an indication for discontinuance of the drug. If serious reactions such as dermatitis occur, BAL and other measures used in arsenical dermatitis may be employed.

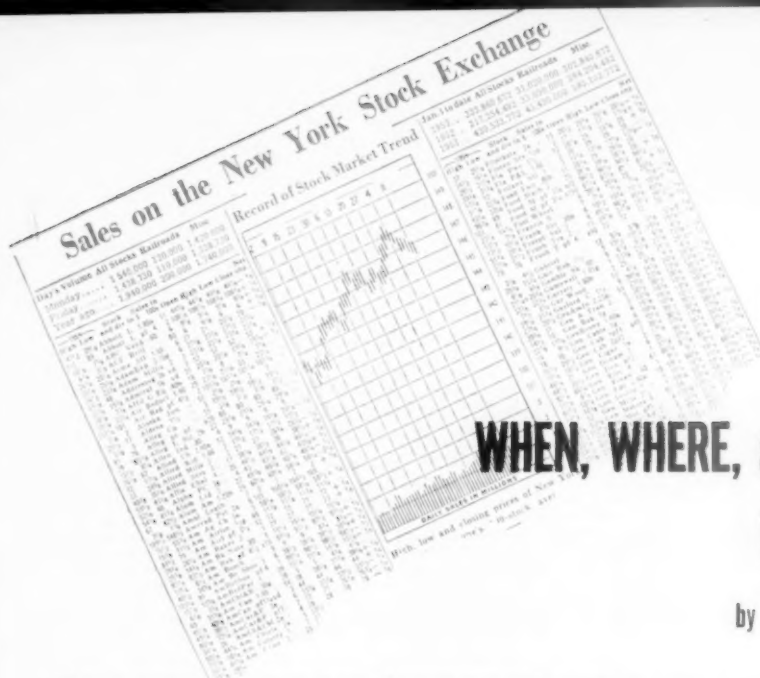
POTASSIUM IODIDE U.S.P. (Antisyphilitic Adjunct)

PRODUCT NAMES: Distributed under official name.

PHARMACOLOGY: Although the iodide ion is nonspecific in action and does not have spirocheticidal properties, sodium or potassium iodide may occasionally be administered as adjunctive therapy in tertiary or late syphilis. The main reason advanced for their use in this late stage of syphilis is the affinity of the iodide ion for granulomatous tissue. Deposited in the granulomatous lesions of syphilis, the iodides seem to hasten the absorption of the syphilitic gumma and thus make the organisms more accessible to the parasitocidal drugs. Before the widespread use of penicillin as an antisyphilitic, the use of potassium iodide along with arsenical and bismuth therapy was considered the most effective form of treatment for patients with gummatous lesions.

DOSAGE: Potassium iodide may be given before meals in order that it may be absorbed as rapidly and as completely as possible. In some instances, enteric coated pills have been used to allay gastro-intestinal irritation. The usual dosage of the saturated solution in water is 1 to 2 cc. in a quarter glass of water or milk three times a day.

UNTOWARD ACTIONS: Iodism, a specific reaction to iodides, is characterized by nasal catarrh, headache, watering of the eyes, and dyspepsia. Skin rashes are also indicative of excessive iodide dosage. If severe toxic symptoms appear during treatment of syphilis, dosage should be reduced to levels that can be tolerated.



WHEN, WHERE, and HOW to invest

by John Y. Beaty*

■ THE WISH to be free from financial worry is universal and nurses are no exception. The nurse who has a backlog of funds for emergencies or for greater monetary enjoyment in daily life need not be haunted by nagging fears of possible financial disaster. She is freer to concentrate on the demands of the present and to enjoy each day as it comes.

When setting up plans for the attainment of this financial freedom, it is wise to first work out a financial program in which you determine the amount you believe you should have in a savings account, the amount you should maintain in your checking account, and the amount of insurance you desire to carry. This is especially true if you have dependents. Insurance may also be considered as a saving for most policies have cash

value. Once you have determined these three items, the remainder will represent the amount you have available for investments in securities. A suggested financial program might be something like this:

Savings account—one-half your yearly expense

Checking account—twice the amount of monthly expense

Insurance—five times your yearly income

Using this as an example, you can work out a financial program of your own varying the amounts according to your judgment and experience. Probably your first investment will be in U.S. Savings Bonds although this item should perhaps be included as part of your basic financial program inasmuch as savings bonds offer a fixed income. They neither provide the opportunities for increased income that stocks do nor do they

*For twenty-four years editor of *Bankers Monthly*, recently editor of *Investor's Future*.

provide protection against higher prices which have the effect of reducing the value of income from savings accounts and government bonds.

"But," you say, "in my busy world how can I find time to study the securities market?"

The answer is, "Employ a corps of experts to watch your investments."

That suggestion doesn't sound very helpful, does it? Where, for instance, will you find these experts? And, if you find them, how will you be able to pay them? However, it is entirely possible for you to employ experts to manage your securities even though you may have only \$100 or less to invest at one time.

A number of years ago, it was realized that there are many people with surplus funds who do not have the time to study the securities market in order to invest these funds safely and profitably. To help these people, a type of organization was formed known as an "investment company." This company employs the necessary experts, and the sole job of these experts is to watch the securities purchased by the company. The investment company, in turn, sells shares to individuals and divides the income from its carefully supervised fund of securities in accordance with the number of shares owned.

Many of these investment companies, over one hundred of which are now in existence, are called "mutual funds." That name explains their organization better than "investment company," for the portfolio of securities is mutually owned by all

of the stockholders in the company.

One of the greatest benefits of owning shares in a mutual fund is that you own a large variety of securities thereby allowing for diversification; diversification is generally considered to be one of the best safeguards against loss in investing. With \$100 to invest you might be able to buy stocks in four or five companies. When you buy one or more shares in a mutual fund, you are buying an interest in the stocks or bonds of several hundred companies.

Some of these funds are made up of common stock in the better American companies; some specialize in bonds; some in preferred stocks; and some, called "balanced funds," include common stock, preferred stock, and bonds. Companies may have an interest in manufacturing enterprises, retailing, public utilities, railroads, oils, and mining. In each field, expert selection is made of securities with preferred records of performance and prospects for an increasingly profitable future.

Mutual funds are commonly referred to as "open-end" companies. This means that you can buy shares in the company directly from the company itself at any time, and you can re-sell these shares to the company whenever you desire. Both the price you pay and the price you receive depend upon the value of the list of securities at the time the sale or purchase is made. In other words, your money is available to you again just as readily as if it had been put into a savings account, or checking account. In the meantime, you have

received your share of income from dividends or bond interest.

There is another type of investment company which is referred to as a "closed-end" company. If you buy shares in this company you must buy them in the open market just as you buy shares in an individual company and, when you sell them, you must sell them in an open market. Consequently, it is not as easy to get your money out of a "closed-end" company. Beginners are, therefore, usually advised to buy shares in an "open-end" company or mutual fund.

In addition to the interest on bonds owned by the fund and the dividends paid on shares, there are often times when the prosperity of a corporation is such that it "splits" its shares so that, without any additional investment, the fund will own twice as many shares in the future.

There are also times when the price of certain stocks goes up on the market to such an extent that the expert managers of the mutual funds think it wise to sell these stocks and replace them with others. Profits made in this way are added to income which is distributed to the mutual fund share owners.

A compilation of the income received from mutual fund shares as compared to the income from securities of individual corporations shows that you may expect as good an average income from this form of investment as from individual investments which require a great deal of time for the investor to supervise and study. Dividends from mutual fund shares vary—most funds pay

dividends quarterly. Many investors leave these dividends in the fund, that is, re-invest them by buying more shares with the dividends. In that way, they build up their investment accounts. Regular detailed reports are supplied to share owners.

You may wonder how much it costs to employ this expert management. It has been shown that an investment of \$10,000 costs from 15c to 20c a day for supervision. This amount is taken from the income received by the fund in dividends and interest and is deducted when your share of the income is determined.

A governmental safeguard helps to ensure that all transactions are handled legally, for mutual fund shares are subject to the Federal Securities Act of 1933 and to the provisions of the Federal Investment Company Act of 1940. The Securities and Exchange Commission, a governmental body, sees to it that these requirements are met.

Where to Get Shares

Many investment dealers will secure investment trust shares for you. They will provide you with printed information about any type of company which may interest you. They will help you analyze this information in the light of your own financial situation, and you can make your purchase of shares through them. If you do not know just where to get in touch with an investment company, you can ask an officer of your bank. If your hours on duty are such that you cannot visit a security dealer you can obtain the needed information, and can make sales and

purchases, as desired, by the mail.

When studying material regarding the activities of various mutual funds, it is well to remember that there are three general types of management. One type concentrates on quality and purchases investments in high grade companies only. Such a company usually owns more bonds and preferred stocks than it does common stock. Safety of the principal and less likelihood of market fluctuation in price are the ruling factors in this type of management.

In medium quality management, stocks and bonds of lesser investment quality usually make up the bulk of the portfolio.

The third type is the speculative type of management in which the company buys speculative securities

which are likely to fluctuate widely in the open market. In return for this greater risk, the shareholders hope for proportionately greater financial rewards.

Obviously, a beginner who has only a small amount of funds to invest is more interested in the high quality type of management which is concerned with capital conservation. It is true, however, that all fund management does its best to avoid losses and increase income. The mutual fund form of safe investment has become so popular that the funds now own over two billion dollars worth of securities. Over a period of years, which has included both deflation and inflation, the record of these mutual funds has been almost perfect. There have been no failures.

Probie



"Don't be afraid."

■ WHEN MY HUSBAND'S attractive business associates refused politely, but firmly, to meet two equally attractive nurse friends of mine, I demanded, and got, their disconcerting reasons. Apparently, no matter how provocative the arrangement of a nurse's personal anatomy, her conversation was invariably strictly from *Materia Medica*. The men contended that the tendency of nurses to talk shop more than their sisters in other professions made them less desirable as dates.

Since nurses are here to stay and, obviously, so are men, I staged a quiz program and came up with some interesting comments—and the name of being very nosey indeed.

What began as a rather mild discussion, on an apparently harmless subject, suddenly mushroomed into a hot and heavy debate until it was obvious we had a conversational bull by the tail and couldn't let go. Sides were chosen, according to the contestant's personal experience with nurses. And like most debates, no matter how serious, this one had elements of humor.

The consensus of masculine opinion indicated nurses were, generally speaking, more toothsome and intelligent than girls in other professions. Indeed, the men admitted, nurses were undoubtedly fine characters. On first appearance, these white-capped angels have been known to cause male pulses to zoom to a dangerous high but a distressing penchant for drifting mentally back to Ward 3 often brings them back to normal with a dull thud. Nurses,

ARE YOU GUILTY of TALKING SHOP?

they felt, have become accustomed to the medical expressions they utter so casually but to mere man these phrases have an ominous and unfeminine sound. Here, again, the secretary has a nasty advantage. She can chatter incessantly about American Tel and Tel or Standard Oil and her words, suggestive of lovely green stuff, fall on enchanted and attentive male ears. But I ask you—what can the poor nurse do with "angina pectoris," "muscular dystrophy," and "hemorrhage?"

Consider poor Tom. "When her big blue eyes looked into mine," he said, "I had the feeling of being diagnosed. Did I have a touch of anemia or was I coming down with jaundice?"

"We're not talking about how they look at you," a champion of nurses reminded, "but how they talk. You were together at that picnic a whole day. Didn't she say anything?"

"Sure. She took one look at my shanks in bathing trunks and mum-



by **Dorothea De Neeffe**

bled something about my 'tibia.' Translated roughly, I gathered that some children, especially fat ones, shouldn't be allowed to walk so soon. Makes 'em bowlegged."

Along this vein, we have the men who are not necessarily embarrassed by blow-by-blow accounts of hospital routine, but rather are made slightly uncomfortable when their dates, undaunted by mixed company, discuss the most intimate subjects in a casual manner. Ye! Even unto the dinner hour.

"Martinis should be served against a background of sentimental music beside a gal who looks and sounds like a dream," Jack observed. "But my gorgeous date was from 'Emergency.' Her perfume was 'Night of Ecstasy' but her earthy chatter threatened 'Asphyxiation.' All through our filet mignon we reset a compound fracture. Fortunately, by coffee-time, I knew the name and address of the super surgeon who performed this worldshaking opera-

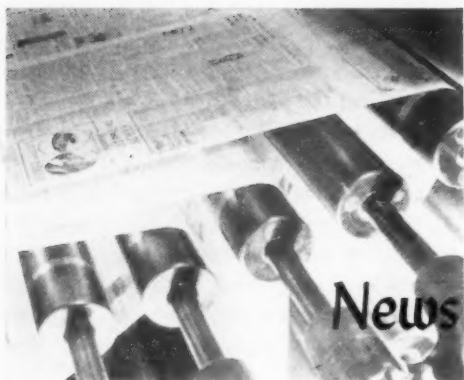
tion. That was one consolation. If I broke a leg in my haste to get my date home, I'd know right where to go!"

A young doctor laughingly admitted that a conversation he might consider enchanting over his cold Borscht might indeed cause another man to turn a delicate chartreuse.

Here the staunch defender insisted that nurses, like doctors, must of necessity learn to insulate themselves against over-sympathy or literally be torn to pieces emotionally. They pointed out that any secretary can enumerate her grievances against the bossman even to the extent of wishing audibly that he'd "turn blue," and no one is particularly shocked. But let the bone-weary nurse yearn wistfully, even in jest, for the untimely demise of the most demanding patient, and she is accused of everything from callousness to downright sadism.

Many of these one-date girls may wonder why, but at the end of a long day most men seem disinclined to deliberately expose themselves to the possibility of a depressing evening. Not when they can be reasonably certain of music, soft lights, and an attentive little pink ear to whisper sweet nothings into.

From the terse "nurses sound unsympathetic" or "too earthy" and "tend to dwell morbidly on death" of the less gabby boys, we come to the more diplomatic fellows who decided that nurses probably weren't really guilty of discussing their work but that man's natural aversion to illness made [*Continued on page 81*]



News in Review

► **PLANS FOR THE 1954 ANA CONVENTION**, to be held April 26-30 in Chicago, are well underway. Headquarters will be in the Conrad Hilton Hotel. All members will register according to their national sections and are reminded to bring their 1954 membership cards on which the name of the section to which they belong must be indicated. Speakers who have been scheduled to appear at general program meetings include Dr. Howard A. Rusk, director of the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, who will speak on "The Nurse's Role in Rehabilitation," and Dr. F. S. C. Northrop, professor of philosophy and law at Yale University Law School, who will speak on "Human Values in a Scientific Age."



► **POLIO IN ALBERTA, CANADA** reached a record high of 1,200 cases and eighty-six deaths during 1953, and the provincial government has announced that it will assume, in addition to the usual 70 cents per patient day, the greater part of the cost of treatment. During the 14-day polio isolation period the government will pay from \$10.25 to \$40 a day for patients in respirators, and the hospital will charge the patient an additional \$2 per day. Payments will be scaled downward in accordance with the severity of the disease and are retroactive to April 1, 1953. It is expected that the new program will raise provincial polio costs to \$1,000,000 by the end of the fiscal year. The province also provides splints, other orthopedic appliances, and nursing services for patients in respirators.



► **SCHOLARSHIPS** for Washington high school graduates interested in nursing have been set up in that state by a number of county tuberculosis associations. Typical of these scholarships are the four which are offered by the Grant County Tuberculosis Association. Students may apply for scholarships leading to either a diploma or a Bachelor of Science degree in nursing. If the student does not complete the course, the money must be refunded. Students wishing to obtain a diploma receive \$150, and those working toward a degree are awarded \$250. Scholarships may be renewed each year but this

practice is not encouraged. Qualification data and application forms are available through the Washington Tuberculosis Association, 1000 Lenore Street, Seattle.



► **TV CLASSES IN HOME NURSING** are to be initiated in Texas under the auspices of the Harris County Chapter of the ARC. The classes will begin the first of this month. Cooperating in the program is the University of Houston School of Nursing, with the university television station donating the required time. The Houston County Chapter of the ARC is recruiting 400 persons to take the course. Half of the 400 will receive seven hours of lessons and seven hours of practice in the classroom; the remaining 200 will receive their instruction only by television and will be required to practice by themselves. The television course will consist of fourteen half-hour shows and will be taught by Beulah Miles, ARC nursing representative. As an additional control, the Oklahoma County Chapter, Oklahoma City, Okla., is recruiting another 200 students to take the regular fourteen-hour course. All three groups will take pre- and post- tests which have been devised by the Educational Testing Service, Princeton, N.J. This service, together with the University of Houston's Department of Psychology, Tests, and Measurements, will evaluate the findings. As consultants in reviewing the tests, Ann K. Magnussen, national director of the ARC Nursing Services, will have Mrs. R. Louise McManus, director of Nursing Education, Teachers College, Columbia University; Margaret Arnstein, chief of the Division of Nursing Resources, USPHS; and Dr. Donald Armstrong, medical director of the Metropolitan Life Insurance Company.



► **CAPITOL COPY:** Rep. Frances P. Bolton (R-Ohio) has received a good initial response to the questionnaires on nursing resources which she mailed to 10,000 prominent Americans. Mrs. Bolton is seeking information to serve as a basis for the drawing up of a new federal bill aimed at alleviating the nurse shortage. According

About People

► Studying at the Medical College of Virginia while on an eight-month furlough from Kahata, Liberia, is **ELLEN MIAMA MOORE**, granddaughter of a Congo chief, and a pioneer in bringing modern techniques to Negro mothers of the African bush... **MRS. EVAN G. RICHARDS** has retired as executive secretary of the Utah State Nurses Association... Two new members have been appointed to the Evaluation and Guidance Service of the NLN. **MRS. MILDRED E. KATZELL** has been named supervisor of test services to schools of nursing and **HELEN VIRGINIA MEHARG** will be assistant director of the service... **GRETCHEN GERDS** has joined the ANA Public Relations staff at headquarters. Miss Gerds succeeds **MRS. JANE JORDAN ROGERS** as assistant executive secretary.

to Mrs. Bolton, the remedy rests in action taken primarily by the states, aided perhaps by incentives and guidance from the national government. In any case, action on the bill which Mrs. Bolton introduced last year for the provision of scholarships for student nurses (H.R. 3850) is necessarily postponed until the report of the Commission on Intergovernmental Relations is out. This Commission has been authorized to study all of the present activities in which states and local governments are the recipients of federal aid . . . The Veterans Administration has announced that it will require financial statements from those applying for hospitalization where the cause of hospitalization is non-service connected. The VA emphasizes that hospitalization will be forthcoming if the applicant signs the specified form signifying inability to pay, providing there is an available bed, and the need for hospitalization has been medically determined . . . The proceedings of the public hearings for national health problems conducted last October by the House Commerce Committee are to be published in a series of five volumes. Volume I consists of testimony presented on cancer and tuberculosis and Volume II is devoted to arthritis, rheumatic diseases, diabetes, and tuberculosis . . . The VA and the USPHS plan to collaborate in a study to determine the relationship between the consumption of tobacco and lung cancer. Some 350,000 veterans will receive questionnaires concerning their smoking habits and their use of snuff or

chewing tobacco. Since most of the veterans will also hold government life insurance, the collection of statistical data on the cause of death will be facilitated.

► **NEW YORK CITY'S AGED** are increasing nine times as fast as the rest of the population, according to a report by the Mayor's Advisory Committee for the Aged. The report states that four years ago there were 550,000 persons 65 years of age or over in the city and that there are now 700,000 in this group. The report, which is the first in a series, declares that ". . . a substantial number of their basic needs are not being met . . ." It cites improvements in the fields of better housing, medical care and research; activity programs carried on in day-care centers; in programs offered by churches, libraries, and summer camps; in volunteer services; in housekeeping services; and in research into the basic problems of the aged. However, the committee points out that too little progress has been made in adult education for the aged; in the wider use of school facilities; and in more realistic age and retirement requirements for employed workers.

► **A BED-BOUND** child needs to be content. This is an important phase of therapy. For this reason, the American Heart Association and its affiliates have published a booklet, *Have Fun . . . Get Well*, which suggests ways in which the patient may amuse himself in bed and is directed primarily to [Continued on page 80]



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Syphilis Today

[Continued from page 51]

in which neurosyphilis may appear is meningovascular neurosyphilis which may occur as acute syphilitic meningitis in early syphilis or as chronic meningitis in late syphilis.

Tabes dorsalis, which appears about fifteen to thirty years after the onset of syphilis, is the result of damage to the central fibers of the sensory neurons. Disturbances of sensation—paresthesias—are early symptoms of the condition. The tabetic may first complain of short, sharp, stabbing pains that dart over the body. Other signs of this condition include an inability to maintain equilibrium when standing with the eyes closed (Romberg's sign) and constriction of the pupils with loss of light reflex (Argyle Robertson pupils).

As incoordination or ataxia progresses, the tabetic patient walks with a slapping gait and has the sensation of walking on a thick carpet because of the paresthesia of the soles of the feet. The gastric crises, so characteristic of tabes, are marked by paroxysmal pain, nausea and vomiting, pallor, sweating, weak pulse, and cold extremities. As the disease progresses further and paralysis ensues, death is usually due to pyelonephritis or pneumonia rather than to tabes.

Perhaps the most tragic consequence of untreated syphilis is general paresis where the brain substance is destroyed by spirochetal invasion. Patients afflicted in this manner undergo a drastic change in per-

sonality, exhibiting such traits as irritability, lack of cleanliness, memory loss, unethical behavior, and excessive sexual activity. Delusions of grandeur or other extraordinary delusions, as well as impairment of judgment, also distinguish the parietic. Difficulty in enunciation, eye changes, intention tremors, skeletal muscle disturbances, and convulsions are some of the physical findings in this deteriorative condition.

Among the innocent victims of syphilis are babies who have either acquired syphilis prior to passage through the birth canal (congenital syphilis) or acquired it during the birth process or soon thereafter. It is generally believed that congenital syphilis is transmitted from mother to fetus through the placenta.

When the mother-to-be is an untreated syphilitic, there are three possible outcomes: syphilis of the fetus resulting in abortion, stillbirth, or birth of a live infant with late syphilis; a live infant with evidence of infection appearing several days or weeks after birth; and a normal infant whose infection may remain latent for months or years. The prognosis is more serious when symptoms appear early.

In early congenital syphilis, the most common symptoms are snuffles, lesions of the skin and mucous membrane, fever, an aphonic cry, and a failure to gain weight. Often the syphilitic infant has the face of a little old man.

In late congenital syphilis, symptoms such as interstitial keratitis and neurosyphilis may appear during

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childhood or adolescence. The presence of Hutchinson's teeth (notched and usually peg-shaped upper middle permanent incisors), interstitial keratitis, and deafness is known as Hutchinson's triad, and is a recognizable sign of congenital syphilis.

Many of the destructive lesions of acquired and congenital syphilis could be prevented if adequate treatment were instituted in the early stages of syphilis and during pregnancy. The difficulty is that cases of syphilis are often hard to find, for syphilis generally causes little discomfort until serious damage has occurred several years after the initial infection.

However, the fact remains that the availability of good treatment has contributed to an unprecedented decline in the reported cases of syphilis during the past five years. Much of this reduction can be attributed to the widespread use of penicillin which has largely replaced the former antisyphilitic arsenicals and bismuth in both early and late syphilis.

In *Drug Digest*, page 52, are discussed four of the agents which are being used in the treatment of syphilis. It is true that penicillin is the most important of the four, but it is also true that the other three, oxophenarsine hydrochloride, bismuth subsalicylate, and potassium iodide, are still resorted to in certain instances when the disease is refractory or when there is unusual sensitivity to penicillin.

In addition to being acquainted with specific antisyphilitic measures, it is well for nurses to know that pa-

tients with syphilis are in need of specific advice and reassurance. Persons in the infectious stage should be advised to sleep alone, avoid coitus and kissing, and use separate eating utensils and toilet articles. Clothing should be aired and surgical dressings destroyed. Infectious patients must not go to barber shops or dentists, or serve in positions that involve intimate contact with people.

The importance of continuing treatment and reporting to the physician cannot be stressed enough, for inadequate treatment can result in serious, infectious relapses. After treatment is completed, there should be a monthly physical examination to detect evidence of relapse. Serologic tests should be done throughout the first year after treatment; after this, semi-annual examinations and serologic tests will usually be sufficient. Also, a post-treatment spinal fluid examination should be made during the sixth month or immediately upon the occurrence of a relapse. Spinal fluid examination is absolutely essential in the recognition of early neurosyphilis.

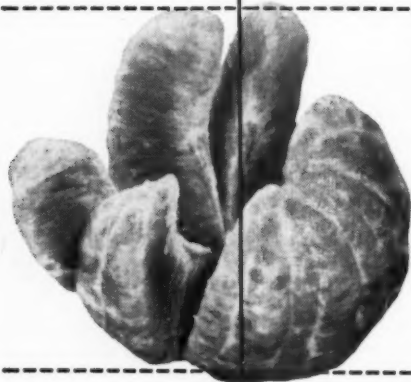
If this advice were followed by all syphilitic patients, there would be an even more dramatic decline in the incidence of the disease than is shown by present-day statistics. One of our most significant jobs as nurses in the control of the scourge of syphilis is to disseminate the correct information on syphilis as widely as possible, and hope that before long the "Great Pox," as syphilis was called in an earlier century, will be as rare as smallpox is today.

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Furthermore, while the value of orange *juice* with its high content of vitamin C should certainly not be minimized, several of the valuable factors in oranges are found in greater quantity in the *meat* of the fruit.

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How R.N.'s Live

[Continued from page 38]

late mornings and skip the cafeteria. The larders are supplied by the hospital with coffee, milk, sugar, bread and butter, jam, and peanut butter.

Radiant heated walls do away with unsightly radiators, and there are trunk rooms and package rooms—the newest conveniences of streamlined modern living. The graduates have certain advantages over students. While the latter have to use the general baths, showers, and lavatories on each floor, graduates share a private bath between each two adjoining rooms. Also, graduates may have their own telephones installed, while students must use the general phone on each floor. Naturally, the graduates come and go as they like, each with her own latch-key. The students observe a curfew.*

With full maintenance provided for all resident R.N.'s, living in Ann Preston Hall is quite economical. The hospital makes no charge for living-in arrangements, and R.N.s may take all their meals at the hospital if they like. However, graduates living away from the hospital are paid a living-out allowance in addition to salary. Gentlemen friends may be entertained in the general lounges, and graduates who like to cook may serve dinner to their women guests from the small adjoining kitchen.

The Arithmetic of Living Out

For those nurses who wish to spend their leisure time away from

the hospital grounds, there are hotel accommodations. One of our interviewees, a private duty nurse, lives in a small midtown New York hotel and pays \$16.50 a week for her room (low for Manhattan). This nurse transferred to a hotel after she gave up a resident job in a New York hospital where the residence was so old and dilapidated, and the beds so bad that many of the nurses bought new ones themselves. Despite its tumble-down character, living at this nurses' home was figured as high as \$30 monthly for the room, \$30 for food, and \$5 for laundry—a \$65 a month salary deduction.

Moving to the small, clean, midtown hotel, where other nurses live too, she found her room comfortable and convenient, but food is still a problem because of today's prices. The \$225 she averages monthly doing private duty at \$12* a day doesn't stretch very far. As she figures it, 20¢ a day goes for car fare; 60¢ to the Registry for the day's work; uniforms have to be laundered every second day (at 50¢ each); and many hospitals impose a charge of 20¢ a day for collecting salaries. This cuts the fee of \$12 daily to \$10.75, out of which comes income tax, Social Security payments, rent, clothing, food, and entertainment. Therefore, in order to eat adequately, she admits to favoring hospitals where the food is good. In this way, she can eat her big meal in the middle of the day, a light supper at night.

In Boston, R.N. visited a pleasant three-room apartment shared by a

*It was ever thus.

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secretary and three young nurses. One nurse is on the operating room staff of Beth Israel Hospital where she earns \$225 a month; another, a visiting nurse, earns \$210 a month; the third, our informant, was a private duty nurse then on a case at the Peter Bent Brigham Hospital. The apartment cost them \$100 a month plus \$15 monthly for the telephone. In addition, each girl puts \$10 a week into the household kitty for food, supplies and replacements.

Our private duty nurse informant told us she is paid the standard Boston rates of \$11.50 a day for private duty nursing and out of this she contributes \$39 a month as her share of the household expenses. Over and above this, she pays \$2 to the Registry for every seven days' work; 30¢ a day for carfare; \$1.80 a week for laundering uniforms (three a week at 60¢ each). After income tax and Social Security deductions are made, she has money enough left for a weekly doctor bill of \$5 and a dental bill of \$4. This medical expense has been going on for a year now. In addition, she spends \$1.50 to \$2 every second week at the hair-dresser, and even manages to save \$5 a week, not week by week, but in a lump sum which she takes out of her pay after working on a long case. All three nurses take evening courses at Boston University—3 credits at \$17.50 each per semester.

Back in New York, we were invited to a three-room apartment on East 35th Street, shared by two Canadian R.N.'s.

After seeing something of the

world and, having tasted apartment living on their own in Canada, they missed the privacy—found it hard to go back to sharing a bathroom, a floor telephone, and entertaining guests in a public reception room. However, because New York was new and strange, when they came they decided to live in the nurses' residence of Roosevelt Hospital until they got their bearings. But when recently a patient asked one of them if she knew of someone who wanted to sublet an apartment, they jumped at the opportunity.

They now have three attractively furnished rooms in a fairly good neighborhood. Their sunny living room has a big casement window with Venetian blinds, draperies of pink-flowered chintz, pretty against the deep green walls, a plushy rug, a sofa, and several upholstered chairs. The furniture is mahogany, and there are several interesting little tables, a chest, lamps galore, and bric-a-brac. The bedroom also has casement windows, hung with rose-color draperies against Wedgewood blue walls. Their furniture includes an antique bed and chest, a small desk, and a studio couch which serves as the second bed.

The apartment costs \$115 plus utilities. Breakfast is negligible, but they eat a hot lunch at the hospital (70¢ each), and whoever gets home first markets on the way in a big supermarket around the corner from the apartment. They figure that food costs them \$1.50 a day per person; bus fare 20¢ a day (to and from the hospital); and laundry's no expense



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whatsoever because the hospital does five uniforms a week free, and they do a sixth one apiece at home.

Neither of them spends much on clothes. They come and go from work in their uniforms, and slip into simple shorts or cotton dresses at home. When they do buy clothes, it's an occasional suit that lasts a long time, or party dresses and shoes. Both girls have paid off large dental bills this year, and were able to afford a two month's holiday last year.

As stated before, these are merely a few examples of how nurses are living in these modern, inflationary times. But even from this small and kaleidoscopic segment of the nurse population, one can discern certain trends. For one thing, it is evident that, though hospitals are generally providing fewer facilities for nurses "living in," when they do, they make an all-out effort to provide the latest in comfort, style, and equipment.

Another fact is evident, too—and that is the increasing tendency of nurses to live within the community rather than within the confining walls of the hospitals. With approximately half of the active nurses in this country married, this is not surprising. Nor is it unusual that many of the unmarried nurses wish to "go it on their own," without depending on nurses' residences. For as the nursing workday has been cut back, with more opportunity for leisure, and as nurses' interests have broadened, nurses have naturally gravitated toward the types of living quarters used by other working women in the community.



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Herpes

[Continued from page 47]

other areas of infection are essential. Repeated applications to the skin of alcohol (grain alcohol or ethyl alcohol or isopropyl alcohol in 55 per cent concentration), is supposed to toughen it. Spirits of camphor is applied to the lip for the same purpose. Keeping a diary is helpful; for example, if herpes labialis appears a day or two after eating chocolate there may be a causal relationship between the two events.

Local treatment of fever blisters begins with cleanliness—soap and water washing and gentle drying. Application of hot or cold, whichever gives the most comfort, is advised. Powder or powder in a fluid as a lotion protects the skin area; the lotion may be applied cold if that gives added relief. Powder in a grease in the form of Lassar's paste covers the spot. Colorless lip pomade, which may be covered with normal, conventional lipstick, may be applied to lip blisters. Systemic medication includes antibiotics and the sulfonamides in a dosage ordered

or administered by the physician.

The common fever blister or cold sore must first be differentiated from impetigo contagiosa. The first sign of impetigo contagiosa is also a blister with a clear content which later becomes purulent. However, when the impetigo vesicle or pustule ruptures, a golden yellow crust forms. New blisters appear elsewhere on the skin, and, usually, other members of the family have the same disease.

Zona or herpes zoster is another blister disease which may be confused with herpes simplex. Zona may appear on one side of the forehead with blisters on the eye surface. If scars form over the eye, blindness follows. This type of herpes zoster or shingles demands the close cooperation of a competent eye specialist. In rare cases of shingles, blisters appear within the ear, and nerve involvement makes swallowing difficult. It should never be taken for granted that forehead blisters are innocuous. In view of the serious complications which may arise when blisters appear in this area, it is well to see your doctor as soon as possible.

3

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Editorial

[Continued from page 31]

the district for the clerical work entailed in collecting state and national dues.

Every effort should be made to relieve nurses busy in their own daily jobs from work that could be done by clerks, typists, and skilled specialists. Too often a few volunteers do the associations' work for the many. Willing nurses many times are so overwhelmed that they are forced to resign their membership to get needed rest.

Nursing associations exist for the purpose of *pooling* nurses' interests and concerns—their hopes—their plans—their ideas, and then translating them into objectives and a work-

ing program. The main contributions from members are their active interest, their ideas, and their capacity to trade these ideas in conferences, committees, and board work.

Only when association members analyze as they propose, evaluate as they move on, and re-allocate emphases periodically, can an organization ever keep an equitable balance between the duties which should be handled by the paid staff and those which must continue to be performed by the members themselves.

Remember throughout your organizational life that the alternative to a "how to do it yourself" program is an autocratic program—doing what someone else tells you to do. There is that much choice.

—ALICE R. CLARKE, R.N., EDITOR



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Alta Bates

[Continued from page 46]

under them. She looked exhausted."

"No," she answered quietly, dropping into a chair, "but they're closing the hospital doors to-morrow!"

"Don't you believe it!" Mr. Hink told her. And he knew what he was talking about, for with the substantial backing of her friends, the hospital kept going.

The hardest part of all, though, was the fact that sick people stayed home during the depression. Only thirty or forty beds of the 112 were occupied, while a staff of nurses had to be fed and paid. Finally, Miss Bates called a meeting and put it up to the nurses to decide whether salaries should be cut or some of them should be dropped from the pay roll. The vote was unanimous to take a salary cut.

When World War II began, Alta Bates took it in her stride and worked in every capacity where she could see a need, including the training of Red Cross nurses' aides and establishing a blood bank. And all this was done by a woman who had by

now reached an age when most people retire.

By 1950, Alta Bates had given over 19,000 anesthetics, conducted a training school for nurses, continually improved conditions in the hospital, held the position of executive for many years, besides mothering and supervising the education of two adopted children. Then one day, she was unable to carry on and was forced to rest—but not before plans had been drawn up for a new wing, designed to provide a total of 250 beds.

At the present time, Alta Bates Community Hospital, a voluntary non-profit organization, serves in part, the Contra Costa County which has increased from 100,000 to 297,000 in the last decade. It employs 130 full-time graduate nurses and twenty-two paid nurses' aides, all living away from the hospital. The flourishing institution is now under the supervision of a board of trustees composed of doctors and civic leaders, several of whom were friends of Alta Bates, the nurse, when she first opened her heart and the doors of her hospital to the people of Berkeley.



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News

[Continued from page 62]

"sick-abled" young people as well as to parents whose children are ill with rheumatic fever or rheumatic heart disease. Actually two booklets in one, the first section was written by Maryelle Dodds, an occupational therapist, and is addressed to teenagers; the second section is for parents of four- to ten-year olds and was prepared by the American Heart Association. Both sections contain suggestions and directions for carrying out activities which can be undertaken while confined to bed, providing the doctor approves. The booklet also includes a comprehensive bibliography and lists sources where working materials can be purchased. Copies are available from the American Heart Association, 44 East 23rd Street, New York 10, N.Y.

► **NEWSLINGS:** The oldest nurses' alumnae association to be formed in the U.S., the Nurses' Alumnae Association of the Woman's Hospital of Philadelphia, celebrated its sixty-fifth anniversary last December . . . Charles H. Silver, member of the Board of Education of New York City, has recommended that the board build a vocational high school for the training of hospital service personnel. Under his plan a training program for a "broad cross section of hospital job classifications" would be set up . . . The state-wide fee for private duty nurses in California, officially adopted at the 1953 CSNA convention, is \$14 per day.

Talking Shop

[Continued from page 59]

the nurses' highly descriptive words and names sound unpleasant. Since the unpleasant seems to linger longer in memory, it probably only seemed that the girls were inclined to talk shop too much.

Now, before you decide to lace my bonbons with arsenic let me hasten to state that, strangely enough, it was the nurses themselves who reduced my indignation from a rolling boil to a simmer. They agreed that some co-workers, who pride themselves on their frankness, often embarrass or actually offend listeners who resent any reference to intimate medical details. These call-a-spade-a-spade gals seem completely oblivious to the fact that most of us don't consider sudden death or serious illness, or all the details of Dr. Smith's latest operation the cheeriest of social small talk.

So what's to do about it? Possibly, it's a good idea just to forget the thermometers and patients like the brainy college graduate who carefully avoids mention of her Phi Beta Kappa Key.

Cupid may well be deaf as well as blind, for despite "shop talk" nurses do marry. The ANA's 1951 Inventory of Professional Registered Nurses established that 46.5 per cent of the 334,733 nurses active in nursing that year, and 85.9 per cent of the 221,884 inactive nurses reported, were married.

February R.N. 1954



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Candid Comments

[Continued from page 42]

nursing the very great importance of developing an informed opinion in the ranks in support of any change. Our official nursing publications are full of medical and treatment information news, organization affairs, et cetera, but I've seen very little that could help the average nurse get perspective on the whole scene, and an understanding of what the planners are aiming at. No field can stand such radical changes unless its practitioners have this understanding.

We cannot recognize the dignity and worth of our profession without acknowledging the just claim of its practitioners to a similar recognition. The conditions under which many nurses work today have robbed them of some of the things that nurses hold most dear—a sense of identity with a high cause, a sense of the dignity of their work, and a deep faith in the ways of their profession. These things are as essential to good nursing as skills and knowledge. The American Catholic Bishops in a statement issued recently said: "Every

man knows instinctively that he is, somehow, a superior being. He knows he is superior to the land he tills, the machine he operates, or the animals which are at his service.

"Even when unable to define this superiority in terms of 'honor' and 'dignity,' if a man enjoys the fruits of his nobility, he is content and accepts that status as his due; lacking honor and dignity for any cause, a man is restless, depressed, even rebellious because something proper to him, as a man, is withheld or denied."

When dignity and honor are "withheld or denied" some nurses become rebellious, and their rebellion is manifested in their care of patients. But many more though "restless and depressed" hold to their faith and give their patients the best they can do under the circumstances. All of us have a duty to help clear away the deep-seated causes of these conditions, for they retard the profession from achieving full stature.

We must not only know the *place* of nursing in our society today, but we must help our profession take and hold that place.

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GENERAL DUTY STAFF NURSES: For 165 bed hospital in residential suburb of Chicago. 40 hr. duty after 9/1/53. Cash salary \$215 for day duty, \$225 for evening duty and \$230 for night duty. Full maintenance in addition to salary includes single room in new nurse's residence plus meals and laundry, which is equivalent to \$335 per mo. Low rental apartments for married nurses, and \$25 additional salary rate for nurses living in their own homes. \$10 increase after 60 days and at regular intervals. Two to four weeks vacation, 6 holidays, sick time policy, free life insurance, Blue Cross hospitalization available. Leave of absence with full salary for post-graduate experience. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

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GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary \$280. \$5 per month tenure increase for each 6 months of service to a maximum of \$310. Social Security, sick leave, prepaid medical and hospital care. \$10 additional for afternoon and night shift, \$10 additional for delivery room, \$20 additional for surgery. Up to 3 weeks vacation at end of 4 years. 7 paid holidays, 8 hr. day, 40 hr. week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GRADUATE NURSES: For a new 93 bed hospital in California. (a) Night Supervisor. (b) Operating Room Supervisor, (c) Scrub Nurses for Surgery. Write Director of Nursing, Memorial Hospital, P.O. Box 942, Modesto, Calif.

GRADUATE NURSES: Public Health Training Program open to graduate nurses 20 to 40 years, \$3889 to \$3971 per year. Trainees take academic work at University while gaining paid experience in field. Other openings for trained public health nurses, 22 to 45 years, \$2971 to \$4350 per year. 40 hr. week, liberal paid vacations, sick leaves, pension system, Civil Service status, educational leaves. Apply Detroit Civil Service Commission, 735 Randolph St., Detroit 26, Mich.

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(1) Sweetman, C. A., J. So. Carolina M. A., 49:38, 1953. (2) Marks, M. M., Am. J. Dig. Dis. 18:219, 1951.
(3) Hamilton, H., in Trans. 5th Am. Cong. Obst. & Gyn., Mosby, 1952, p. 69. (4) Burnikel, R. H., & Sprecher, H. C., Am. J. Dig. Dis. 19:191, 1952. (5) Marks, M. M., Personal Communications, 1952-53.

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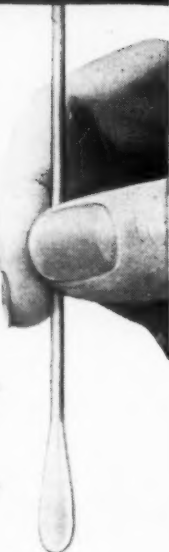


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*Portis, Sidney A., Life Situations, Emotions and Hyperinsulinism,
J.A.M.A. 142: 1281-1286 (April 22) 1950.



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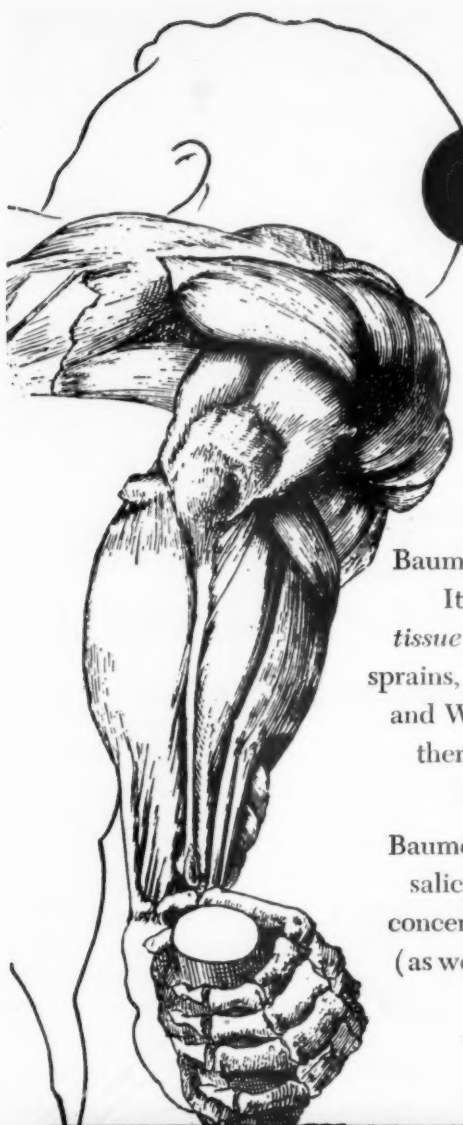
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I. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

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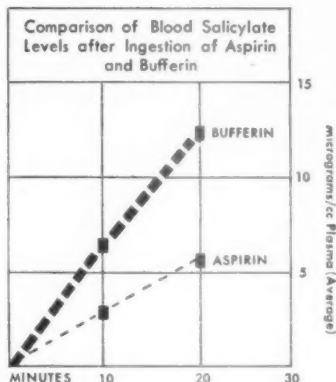
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1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950

2. Gastric Tolerance for Aspirin and Buffered Aspirin. Ind. Med. 20:480, Oct. 1951



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